Nature of the clinical difficulties of first-year family medicine residents under direct observation

Alain Beaumier,* MD, CCFP; Georges Bordage,† MD, PhD; Danielle Saucier,* MD, CCFP; Jean Turgeon,* MD, CCFP

Objective: To determine and classify the difficulties of first-year family medicine residents observed during clinical interviews.
Design: Retrospective, descriptive study.
Setting: Family practice unit at a teaching hospital.
Participants: Forty-seven of the 56 first-year family medicine residents during their 2-month compulsory rotation in ambulatory family medicine, between July 1983 and December 1988, and 4 physicians who supervised the residents.
Main outcome measure: The residents' difficulties noted on the observation forms.
Main results: A total of 1500 difficulties were observed during 194 interviews, an average of 7.7 (standard deviation 5.2) per interview. There were 167 different difficulties, which were classified into seven categories (introduction, initial contract, body of the interview, techniques and organization, interpersonal aspects, final contract and miscellaneous) and 20 subcategories. The 17 most frequently noted difficulties accounted for 40% of the total.
Conclusions: The results constitute a useful starting point for developing a classification of residents' difficulties during clinical interviews. We believe that the list of difficulties is applicable to residents at all levels and in other specialties, especially in ambulatory settings. The list can be used to develop learning materials for supervisors and residents.

Objectifs : Préciser et classer en catégories les difficultés des résidents de première année en médecine familiale observés au cours d'entrevues cliniques.
Conception : Étude rétrospective descriptive.
Cadre : Unité de médecine familiale dans un hôpital universitaire.
Participants : Quarante-sept des 56 résidents de première année en médecine familiale pendant leur stage obligatoire de 2 mois en médecine familiale ambulatoire entre juillet 1983 et décembre 1988 et 4 médecins qui ont supervisé les résidents.
Principale mesure des résultats : Les difficultés des résidents consignées sur les formules d'observation.
Principaux résultats : Au total, 1 500 difficultés ont été observées au cours de 194 entrevues, soit une moyenne de 7,7 (écart type 5,2) par entrevue. Nous avons dégagé 167 difficultés différentes, classées en sept catégories (introduction, contact initial, corps

*From the *Unité de médecine familiale, Hôpital Laval, Sainte-Foy, Que., and the †Bureau de pédagogie des sciences de la santé, Faculté de médecine, Université Laval, Sainte-Foy, Que.*

Version française disponible sur demande auprès les auteurs.

Reprint requests to: Dr Alain Beaumier, Unité de médecine familiale, Hôpital Laval, 2725, ch. Sainte-Foy, Sainte-Foy, QC G1V 4G5

← For prescribing information see page 648

de l'entrevue, techniques et organisation, aspects interpersonnels, contact final et divers) et 20 sous-catégories. Les 17 catégories les plus fréquentes représentaient 40 % du total.
Conclusions : Les résultats constituent un point de départ utile pour l'élaboration d'une classification des difficultés des résidents pendant les entrevues cliniques. Nous croyons que la liste des difficultés peut s'appliquer aux résidents à tous les niveaux et dans d'autres spécialités, particulièrement en milieu ambulatoire. La liste peut servir à l'élaboration de matériel didactique pour les superviseurs et les résidents.

Direct observation of first-year residents in family medicine through a one-way mirror is a common teaching method in family medicine residency programs. Wakefield[1] considers direct observation to be the ideal formative or summative method for evaluating clinical performance. The type of student observed varies,[2-10] as does the way in which the method is applied.[9,11-14] The observation forms completed by the supervisor also vary according to the student's specialty or level of training. The forms may be very detailed and may be in the form of checklists,[4,15] or they may take the form of a general framework applicable to various types of interview.[6-8] Many checklists have been developed especially for the Objective Structured Clinical Examination and were usually derived from program objectives or textbook models.[16-18]

However, the information from these observations has not been extensively analysed. Research has focused mainly on the validity and reliability of the observation tools used and the interjudge reliability of the supervisors' observations.[1] Few studies exist on the nature of the difficulties noted. Of 20 studies on direct observation identified from a MEDLINE search covering 15 years only 3 dealt with the nature of the difficulties. Meuleman and Caranasos[6] presented a list of 29 difficulties observed among interns in internal medicine. Certain items were phrased positively (e.g., appropriate control of interview) and others negatively (e.g., no psychiatric history obtained). Wiener and Nathanson[12] studied the difficulties encountered in the physical examination in internal medicine and classified them into five types of error: technique, omission, detection, interpretation and recording. They also presented a list of the most frequent difficulties in physical examination by anatomic region and category of error (e.g., errors in techniques to examine head and neck [bimanual palpation of the thyroid] or errors in detection [thyroid nodules]). Stewart and colleagues,[10] using a model developed at the University of Western Ontario, London,[19,20] evaluated the patient-centred clinical method of residents in family medicine. The resident's responses to what the patient said were classified as adequate or not and as cut off or not.

These three studies provide only fragmentary observations on residents' difficulties during clinical interviews. The conclusions deal mainly with the use of lists of difficulties as evaluation tools rather than with the nature of the difficulties noted. We performed a study to compile more systematically the difficulties of first-year family medicine residents observed during clinical interviews in order to develop a classification of such difficulties.

Methods

The study was based on the experience of first-year residents and physician-teachers in a family practice unit, the Unité de médecine familiale, at Hôpital Laval, Quebec, between July 1983 and December 1988.

The general objective of direct observation of first-year family medicine residents is to create an awareness of the structure and characteristics of an interview in family medicine so that the residents can define their learning objectives and the means to achieve them. The structure of the interview (the initial contract, the body of the interview [history-taking and physical examination related to specific diagnostic hypotheses] and the final contract) is the main focus. Other aspects of the interview, such as the physician–patient relationship, are also observed.

Each resident is observed directly in an actual clinical setting during two or three sessions consisting of two interviews each. The physician-supervisor sits behind a one-way mirror and notes on a form his or her observations about the structure of the interview and the physician–patient relationship. The last section of the form is used to note the feedback that will be discussed with the resident as well as appropriate educational prescriptions. Supervisors are not limited in the range of observations. All strengths and weaknesses as perceived by each observer are noted. When there is more than one supervisor each person completes a form, but the feedback and educational prescriptions are arrived at through consensus. During the feedback session the resident's strong and weak points are discussed, and the means to improve the resident's performance (the educational prescription) are clearly defined.

The observation forms for 47 (84%) of the 56 first-year family medicine residents at the unit during the study period were found, representing a total

of 194 interviews. Of the nine residents for whom the forms could not be found eight were at the unit during the first year of the study. Of the 299 observation forms for the 47 residents 26 were missing. Because the missing forms likely affected the frequency rather than the nature of the difficulties, we analysed the 273 forms found. The patients' clinical problems were not tabulated because this information was not required on the observation form. However, Aubin and associates[21] showed that, overall, the residents' interviews at the unit cover a wide range of clinical problems encountered in an ambulatory family medicine setting and are not limited, for example, to psychosomatic complaints or minor cases.

Four physicians with 8 months, 4 years, 7 years and 8 years of experience with direct observation supervised the residents. They did not receive any specific training in direct observation techniques. Half the interviews took place with only one supervisor present, 46% with two supervisors present and 4% with three supervisors present.

Three of the supervisors coded their own forms, and the forms of the fourth supervisor were coded by a colleague (J.T.), who was familiar with the supervision process. Codes were assigned to the resident under observation, the date of the interview, the supervisor(s) present and the difficulties noted. Each difficulty was given a specific name and an identification number. We deliberately chose to have each supervisor code his or her own forms because this method reflected the study's main objective — to describe exhaustively each supervisor's perception of the difficulties encountered by the residents, not to verify the interjudge reliability of the supervisors' observations.

The list of difficulties was established not *a priori* but, rather, as the observation forms were coded. The difficulties were coded in sets of 20 forms. In the first set eight forms were also coded by the three other supervisors to verify the terminology used by the coders. The same difficulties were identified by all four supervisors. Because the exact terms used to denote the difficulties varied slightly, it was decided that the group would standardize the designation of each difficulty while staying as close as possible to the original expressions. Thus, a systematic check of all the forms by a second coder was not deemed necessary. The designation of any new difficulty was subject to consensus, and any ambiguity as to the exact nature of a difficulty was discussed. On a few occasions a new difficulty prompted the supervisors to review previous forms.

Results

A total of 1639 difficulties were noted. When an identical difficulty was noted by two supervisors during one interview the difficulty was tallied only once; this occurred 126 times. In addition, 13 forms that were marked "no difficulty" were excluded. Of the remaining 1500 difficulties 37 (2.5%) were either impossible to interpret (in 35 cases) or illegible (in 2) and were classified as miscellaneous. An average of 7.7 (extremes 0 and 24, standard deviation 5.2) difficulties were noted per interview. The supervisors noted 1 to 12 difficulties in about two-thirds of the interviews and 13 to 24 in the remaining third.

In all, 167 different difficulties were identified (Appendix 1). The difficulties identified for a given subject were very diverse (e.g., 6 difficulties related to the history of the present illness and 10 to the overall process of the final contract). The difficulties were classified by category and subcategory *a posteriori* to produce a practical, easy-to-use classification (Table 1). The categories are based on terminology currently used in family medicine and generally reflect the various components of a clinical interview. In cases in which the terms for the difficulty were synonymous (e.g., "automated history-taking" and "does not question in relation to hypotheses") they were grouped together, as were variations on the same theme with the same educational consequences (e.g., "pays too much or too little attention to the third person"). Certain practices are not necessarily wrong (e.g., "postpones the physical examination until another interview"); they were noted as difficulties only when they were inappropriate for the context. Two types of designation were used: directly observable behaviour (e.g., "uses negative questions" and "does not perform an examination technique properly") and interpretations (e.g., "treats the patient like a child" and "is scattered for lack of a structure"). Interpretations were more likely to be used for difficulties with interpersonal skills than with other skills.

Table 2 shows the 17 most frequently noted difficulties. They accounted for two-fifths of the total (604/1500). In the case of improper execution of a physical examination technique the technique in question was noted on the observation form. In 18 cases out of 40 the technique involved was measurement of the blood pressure; problems with various other techniques were noted once or twice each.

Discussion

Our main goal was to compile a list of the clinical difficulties of first-year residents in family medicine noted during direct observation. The low frequency of each difficulty highlights the diversity of the problems noted. On the other hand, 17 (10%) of the 167 different difficulties accounted for two-fifths of the total number of difficulties noted. Each

of the five most frequently observed difficulties was noted in one-fifth to one-third of the interviews.

The frequency of each difficulty must be interpreted with caution because the study was conducted in only one family practice unit with only four supervisors. However, our list represents an important starting point that may be refined through similar studies in other settings. Moreover, the fact that each difficulty was counted only once for each interview may have led to underestimation of the frequency of errors repeated several times during the course of an interview. Furthermore, the frequency of a difficulty is not the only indication of its importance. For example, failure to reach a diagnostic conclusion (observed 7 times) has far more serious consequences than the use of negative questions (noted 40 times). During the feedback sessions the supervisors took into account factors other than frequency, such as the consequences of the difficulty for the interview as a whole and its effect on the resident's attitude toward the interview, in deciding which items to discuss with the resident.

The variety of difficulties and the low rate of duplication of difficulties when more than one supervisor was present (126 [13%] of 940 difficulties) highlight the wide range of perceptions among the supervisors. Several factors influence the type of difficulty noted by a supervisor: the patient's illness and personality, the resident's skills and personality, the numerous facets of an interview and the supervisor's own area of special interest. Each supervisor may focus on particular aspects of the clinical process (e.g., structure of the interview, interpersonal skills, diagnostic process and examination techniques), depending on his or her experience. Each resident's evaluation is influenced by the supervisor's personal views. Consequently, our list of difficulties is not the result of an *a priori* definition of the residents' difficulties but, rather, the result of the overall perceptions of all four supervisors over a 5-year period.

The variety of the supervisors' perceptions raises the problem of standardization. In a summative context this diversity is most undesirable. However, in a formative context it can be an advantage. In the same way that residents are exposed to different styles of practice with various attending physicians, they may benefit from a diversified evaluation as long as the overall training objectives are met.

Table 1: Frequency of difficulties observed among first-year family medicine residents by category and subcategory

Category; subcategory	No. (and %) of difficulties (n = 1500)
Introduction	35 (2.3)
Presentation of mirror	8
Identification of roles	9
Miscellaneous	18
Initial contract	140 (9.3)
Contract definition	129
Contract fulfilment	11
Body of interview	587 (39.1)
Present illness	271
Review of systems, past history, habits, psychosocial history	41
Particular situations	66
Physical examination	209
Techniques and organization	386 (25.7)
Interviewing skills	264
Explanations to patient during interview	42
Sequence of interview	12
Material and temporal organization	68
Interpersonal aspects	144 (9.6)
Resident's emotions	33
Empathy, understanding	60
Respect	51
Final contract	171 (11.4)
Overall process	52
Management	28
Explanations and advice	61
Feedback from patient	30
Miscellaneous	37 (2.5)

The fact that the difficulties were noted either as observable behaviour or as interpretations raises important problems of communication among supervisors and between supervisors and residents. A hasty interpretation may be erroneous and may lead to negative reactions from residents. We believe that it is preferable to first note observable behaviours and discuss them with the resident and then attempt an interpretation and discuss it with him or her.

Our results constitute a useful starting point for developing a classification of residents' difficulties during clinical interviews. Although the study was based on the observation of first-year family medicine residents, we believe that the list of difficulties also applies to residents at all levels and in other specialties, especially in ambulatory settings. We presented the list to internists and pediatricians, who found it quite appropriate for their residents. The classification is an important tool for supervisors and residents alike. It draws their attention to the various types of difficulty that can occur and provides a standard, common vocabulary. It is up to individual users to apply this tool and to adapt and refine it according to their specific training objectives.

We thank Sylvie Martin for her help with data processing and Rhône-Poulenc Pharma Inc., Montreal, for its financial support for translation.

References

1. Wakefield J: Direct observation. In Neufeld VR, Norman GR: *Assessing Clinical Competence*, Springer Pub, New York, 1985: 51–70

Table 2: Difficulties most frequently noted among the residents

Difficulty	No. (and %) of times observed (n = 1500)	% of interviews (n = 194)
Does not clearly define the data (incomplete history-taking)	69 (4.6)	35.6
Does not perform an examination technique properly	58 (3.9)	29.9
Does not establish an initial contract	47 (3.1)	24.2
Is scattered for lack of a structure; collects data in a disorganized fashion	42 (2.8)	21.6
Uses negative questions	40 (2.7)	20.6
Lacks diagnostic hypotheses	35 (2.3)	18.0
Difficulty noted but impossible to interpret	35 (2.3)	18.0
Does not perform the physical examination with diagnostic hypotheses in mind	34 (2.3)	17.5
Provides imprecise or contradictory advice or is hesitant	34 (2.3)	17.5
Exceeds allotted time	34 (2.3)	17.5
Omits partially or completely the review of systems	29 (1.9)	14.9
Does not question in relation to hypotheses (automated history-taking)	27 (1.8)	13.9
Omits an important element of the physical examination; does not objectify a symptom	24 (1.6)	12.4
Has the patient undress progressively; does not have the patient use a gown	24 (1.6)	12.4
Allows the patient to control the interview	24 (1.6)	12.4
Does not seek feedback from the patient	24 (1.6)	12.4
Is imprecise or incomplete in the final contract	24 (1.6)	12.4
Total	604 (40.3)	

2. Alexander DA, Knox JDE, Morrison AT: Medical students talking to patients. *Med Educ* 1977; 11: 390-393
3. Connolly J, Bird J: Video-tape in teaching and examining clinical skills: a short-case format. Ibid: 271-275
4. Harper AC, Roy WB, Norman GR et al: Difficulties in clinical skills evaluation. *Med Educ* 1983; 17: 24-27
5. Comstock LM, Hooper EM, Goodwin JM et al: Physician behaviors that correlate with patient satisfaction. *J Med Educ* 1982; 57: 105-112
6. Meuleman JR, Caranasos GJ: Evaluating the interview performance of internal medicine interns. *Acad Med* 1989; 64: 277-279
7. Hinz CF: Direct observation as a means of teaching and evaluating clinical skills. *J Med Educ* 1966; 41: 150-161
8. Links PS, Colton T, Norman GR: Evaluating a direct observation exercise in a psychiatric clerkship. *Med Educ* 1984; 18: 46-51
9. Gladfelter T, Barnes T: The effectiveness of evaluation by observation. *Fam Pract Res J* 1983; 3: 107-113
10. Stewart M, Brown J, Levenstein J et al: The patient-centred clinical method: 3. Changes in residents' performance over two months of training. *Fam Pract* 1986; 3: 164-167
11. Corley JB, Mason RL: A study on the effectiveness of one-way mirrors. *J Med Educ* 1976; 51: 62-63
12. Wiener S, Nathanson M: Physical examination: frequently observed errors. *JAMA* 1976; 236: 852-855
13. Enelow AJ, McKinney Adler L, Wexler M: Programmed instruction in interviewing: an experiment in medical education. *JAMA* 1970; 212: 1843-1846
14. Tiberius RG, Sackin HD: Observation as a method of learning: A useful learning experience or a waste of time? *Med Educ* 1988; 22: 287-293
15. *Handbook for Certification in Family Medicine*, College of Family Physicians of Canada, Toronto, 1988: 31-34
16. Lehmann F, Côté L, Bourque A et al: Physician-patient interaction: a reliable and valid check-list of quality. *Can Fam Physician* 1990; 36: 1711-1716
17. Frost GJ, Cater JI, Forsyth JS: The use of the Objective Structured Clinical Examination (OSCE) in paediatrics. *Med Teach* 1986; 8: 261-269
18. Petrusa E: *Collaborative Project to Improve the Evaluation of Clinical Competence*, Final Report to the National Fund for Medical Education, Washington, 1988
19. Brown J, Stewart M, McCracken E et al: The patient-centred clinical method: 2. Definition and application. *Fam Pract* 1986; 3: 75-79
20. Levenstein JH, McCracken EC, McWhinney IR et al: The patient-centred clinical method: 1. A model for the doctor-patient interaction in family medicine. Ibid: 24-30
21. Aubin M, Vézina L, Fortin JP et al: *Effet d'un projet d'intervention sur le dépistage de l'hypertension artérielle*, Rapport de recherche présenté au Conseil régional de la santé et des services sociaux, Région 03 Québec, Québec, 1990

Appendix 1: Difficulties of first-year family medicine residents under direct observation*

Difficulty	Classification no.†
Introduction (100)	
Presentation of mirror (110)	
Informs the patient of the mirror and its purpose before entering the examination room	110.01
Informs the patient of the mirror imprecisely or incompletely	110.02
Informs the patient of the mirror excessively	110.03
Identification of roles (patient, resident and supervisor) (120)	
Does not identify who is being observed (resident or patient)	120.01
Does not properly define the respective roles of the supervisor (behind the mirror) and the resident	120.02
Does not identify the supervisor(s)	120.03
Miscellaneous (130)	
Speaks to the supervisor across the mirror	130.01
Does not identify himself	130.02
Does not attend to the patient's comfort	130.03
Does not identify the patient's usual attending physician; does not identify himself as the current care provider	130.04
Initial contract (200)	
Contract definition (210)	
Does not clearly identify the chief complaint; leaves it imprecise	210.01
Does not seek the patient's real demand; leaves it imprecise	210.02
Does not clearly define the contract; takes a prior agreement for granted	210.03
Defines a contract that is too limited	210.04
Searches for a problem where there is none	210.05
Does not make a selection among the problems presented; does not clearly distinguish between two problems	210.06
Does not establish an initial contract	210.07
Unilaterally establishes an initial contract	210.08
Establishes an initial contract late in the interview	210.09
Contract fulfilment (220)	
Does not fulfill the established initial contract	220.01
Exceeds the established initial contract	220.02

Difficulty	Classification no.†
Body of the interview (300)	
Present illness (310)	
History-taking (311)	
Does not clearly define the data (incomplete history-taking)	311.01
Does not question in relation to hypotheses (automated history-taking)	311.02
Omits a key element	311.03
Does not differentiate between important and secondary elements; pays too much attention to irrelevant details	311.04
Takes the patient's words for granted	311.05
Places too much importance on certain parts of the history (e.g., psychosocial history, physical activity)	311.06
Diagnostic hypotheses (312)	
Lacks diagnostic hypotheses	312.01
Does not verify his diagnostic hypotheses	312.02
Formulates diagnostic hypotheses late in the interview	312.03
Sticks to only one or two diagnostic hypotheses	312.04
Diagnosis (313)	
Does not recognize the relation between various symptoms; is late in recognizing the relation	313.01
Lacks a global view of the problem	313.02
Makes a diagnosis prematurely	313.03
Lacks precision in his diagnostic conclusion(s)	313.04
Considers rare diagnoses before common ones	313.05
Fails to reach a diagnostic conclusion	313.06
Omits a problem	313.07
Lacks knowledge concerning the diagnosis	313.08
Structure (314)	
Is scattered for lack of knowledge	314.01
Is scattered for lack of a structure; collects data in a disorganized fashion	314.02
Review of systems, history and psychosocial history (320)	
Omits partially or completely review of systems	320.01
Uses automated questions	320.02
Performs a review of systems that is unrelated to the patient's situation; spends too much time on irrelevant systems	320.03
Obtains the psychosocial history at an inappropriate moment	320.04
Does not obtain the psychosocial history; leaves it imprecise	320.05
Particular situations (330)	
Periodic health examination (PHE) (331)	
Does not integrate the PHE into the interview	331.01
Performs an incomplete PHE (e.g., according to risk factors or age group)	331.02
Lacks an overall structure for a PHE	331.03
Does not explain the purpose of the PHE to the patient	331.04
Miscellaneous (332)	
Lacks an overall structure for follow-up visits	332.01
Lacks an overall structure for preoperative assessments	332.02
Physical examination (340)	
Contents (341)	
Does not perform the physical examination with diagnostic hypotheses in mind	341.01
Scattered for lack of a structure; performs a disorganized examination	341.02
Performs an automated, irrelevant physical examination	341.03
Omits an important element of the physical examination; does not objectify a symptom	341.04
Postpones the physical examination until another interview	341.05
Erroneously interprets a sign	341.06
Repeatedly examines the same system or the same sign	341.07
Examination techniques (342)	
Is slow in performing examination techniques	342.01
Does not give clear instructions to the patient	342.02
Does not perform an examination technique properly	342.03
Is improperly positioned in relation to the patient	342.04
Moves around the examination table unnecessarily	342.05
Talks throughout the examination	342.06
Disrobing problems (343)	
Watches the patient undress or dress	343.01

continued on page 496

Difficulty	Classification no.†
Undresses the patient	343.02
Has the patient undress progressively; does not have the patient use a gown	343.03
Techniques and organization (400)	
Interviewing skills (410)	
Questions (411)	
Uses closed questions	411.01
Uses suggestive questions	411.02
Uses imprecise questions; does not complete questions	411.03
Uses multiple questions	411.04
Uses negative questions	411.05
Hesitates while formulating a question; searches for questions	411.06
Repeats questions	411.07
Does not give the patient sufficient time to answer	411.08
Does not insist on obtaining essential information	411.09
Vocabulary (412)	
Uses language or medical terms incomprehensible to the patient	412.01
Uses the expression "we" or "us"	412.02
Uses the expression "a little bit"	412.03
Addresses the patient inappropriately (e.g., uses patient's first name or "buddy" language)	412.04
Multiple actions (413)	
Takes notes at an inappropriate moment	413.01
Looks in the medical record before questioning the patient	413.02
Focuses on the medical record	413.03
Speaks to the patient while talking on the telephone	413.04
Speaks at the same time as the patient	413.05
Control of the interview (414)	
Controls the interview excessively	414.01
Allows the patient to control the interview	414.02
Miscellaneous (415)	
Has a verbal tic or twitching	415.01
Speaks in a monotone	415.02
Speaks too quickly	415.03
Talks too much	415.04
Changes the subject suddenly or inappropriately	415.05
Reformulates questions or statements inadequately or too often	415.06
Pays too much or too little attention to the third person	415.07
Does not look at the patient	415.08
Does not listen to the patient	415.09
Loses train of thought after a distracting event (e.g., a telephone call)	415.10
Explanations to the patient during the interview (420)	
Does not offer pertinent explanations	420.01
Explains in an imprecise manner	420.02
Sequence of the interview (430)	
Uses inappropriate sequence to conduct the interview (e.g., obtains history before asking about chief complaint)	430.01
Examines the patient while obtaining the history	430.02
Asks questions during the physical examination	430.03
Completes the history-taking or physical examination during the final contract	430.04
Material and temporal organization (440)	
Organization (441)	
Does not have the patient's medical record on hand when needed	441.01
Does not consult the medical record at appropriate times	441.02
Consults the medical record inefficiently	441.03
Forgets to complete a form (e.g., driver's licence form, request for x-ray)	441.04
Poorly organizes physical examination materials	441.05
Time management (442)	
Is slow throughout the interview	442.01
Exceeds allotted time	442.02
Conducts the interview hastily	442.03
Interpersonal aspects (500)	
Resident's emotions (510)	
Is uncomfortable with certain topics (e.g., sex, sadness, death)	510.01
Is intimidated by the patient; gives up easily	510.02
Controls his uncertainty poorly	510.03

Difficulty	Classification no.†
Transfers his uncertainty to the patient	510.04
Lacks confidence	510.05
Does not confront the patient sufficiently	510.06
Empathy, understanding (520)	
Does not notice the patient's emotions (e.g., anxiety, impatience)	520.01
Rationalizes the patient's emotions	520.02
Does not take the opportunity to explore or reflect back the patient's emotions	520.03
Minimizes the patient's complaints or problems	520.04
Is afraid to worry the patient	520.05
Remains distant	520.06
Makes a hazardous, inappropriate or erroneous interpretation	520.07
Argues with the patient	520.08
Respect (530)	
Does not answer the patient's requests or questions	530.01
Deliberately avoids a problem presented by the patient	530.02
Laughs inappropriately	530.03
Is prejudiced or offers value judgements	530.04
Lacks respect	530.05
Reassures the patient prematurely, insufficiently or inappropriately	530.06
Treats the patient like a child	530.07
Tries to please the patient at any cost	530.08
Becomes impatient or aggressive	530.09
Is curt or lacks warmth; raises voice or is pompous	530.10
Final contract (600)	
Overall process (610)	
Does not establish a final contract	610.01
Presents a disorganized final contract	610.02
Is imprecise or incomplete in his final contract	610.03
Does not sufficiently support his final contract on the data collected	610.04
Discredits his physical examination or investigation	610.05
Starts the interview over again	610.06
Commits himself before consulting the supervisor	610.07
Consults the supervisor prematurely	610.08
Does not explain his absence to consult with the supervisor	610.09
Leaves the diagnostic or therapeutic decision to the supervisor	610.10
Management (620)	
Suggests treatment when the problem is not clearly established	620.01
Wants to do something at any cost	620.02
Does not use a simple existing solution	620.03
Suggests an inappropriate investigation or treatment	620.04
Does not make the patient responsible for his well-being	620.05
Does not ensure follow-up	620.06
Does not use his influence as a physician	620.07
Explanations and advice (630)	
Provides automated advice that is not suited to the patient	630.01
Provides inappropriate advice	630.02
Provides imprecise or contradictory advice or is hesitant	630.03
Provides erroneous advice or explanations	630.04
Provides too much advice	630.05
Does not explain diagnostic hypotheses or diagnosis	630.06
Explains too quickly	630.07
Does not relate the patient's symptoms and emotions	630.08
Feedback from patient (640)	
Does not seek feedback from the patient	640.01
Seeks too much feedback from the patient	640.02
Does not give the patient sufficient time to react	640.03
Imposes his conclusions; does not negotiate	640.04
Miscellaneous (700)	
Difficulty noted but impossible to interpret	700.01
Difficulty noted but illegible	700.02

*Each statement refers to the resident; "his" is used generically.
†The numbering system contains five digits: the first indicates the category, the second the subcategory, the third the sub-subcategory and the last two the difficulty.